



Health Care for the Homeless

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Bibliography #3

Oral Health Needs of Homeless People

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2001

Wilbanks DS. **Reaching out – TDA dentists strive to meet the access challenge.** Tex Dent J, 118(2) 154-63, March 2001.

Zabos GP, Trinh C. **Bringing the mountain to Mohammed: a mobile dental team serving a community-based program for people with HIV/AIDS.** Am J Public Health, 91(8): 1187-9, August 2001.

In spite of the direct referral system and family-centered model of primary health care linking medical and dental care providers, most HIV-positive patients at the Columbia Presbyterian Medical Center received only emergency and episodic dental care between 1993 and 1998. To improve access to dental care for HIV/AIDS patients, a mobile program, called WE CARE⁺ was developed and collocated in community-based organizations serving HIV-infected people. WE CARE provided preventive, early intervention, and comprehensive oral health services to minorities, low-income women and children, homeless youths, gays and lesbians, transgender individuals, and victims of abuse. More efforts to collocate dental services with HIV/AIDS care at community-based organizations are urgently needed.

2000

Locker D. **Deprivation and oral health: a review.** Community Dent Oral Epidemiol, 28(3):169, June 2000.

The link between socioeconomic status and health, including oral health, is well established. The conventional measures of socioeconomic status used in these studies, such as social class and household income, have a number of weaknesses so that alternatives, in the form of area-based measures of deprivation, are increasingly being used. This paper reviews epidemiological research linking deprivation and oral health. Four types of study are identified and described: simple descriptive, comparative, analytic, and explanatory. These studies confirm that deprivation indices are sensitive to variations in oral health and oral health behaviors and can be used to identify small areas with high levels of need for dental treatment and oral health promotion services. As such, they are likely to provide a useful administrative tool. In terms of research, the studies demonstrate that these measures provide a ready way of controlling for socioeconomic status in studies examining the association between oral health and other variables. However, this research, in largely replicating previous studies using social class, does not address fundamental issues concerning the mechanisms which link social inequality and health. Deprivation measures have a major role to play in research that examines features of people and places, and how they promote and/or damage both oral and general health.

Oral health in America: a report of the Surgeon General. U.S. Dept. of Health and Human Services, May 2000.

The first-ever Surgeon General's report on oral health identifies a "silent epidemic" of dental and oral diseases that burdens some population groups and calls for a national effort to improve oral health among all Americans. The report also focuses on the relationship between oral health and overall good health throughout life, the mouth as a "mirror for general health and well-being and the association between oral health problems and other health problems." Major barriers to oral health include socioeconomic factors, such as lack of dental insurance or the inability to pay out of pocket, or problems of access that involve transportation and the need to take time off from work for health needs. While 44 million Americans lack medical insurance, about 108 million lack dental insurance. Meanwhile, uninsured children are 2.5 times less likely to receive dental care than insured children, and children from families without dental insurance are 3 times as likely to have dental needs as compared to their insured peers. This report charts a broad course of action including: enhancing the public's understanding of the meaning of oral health and the relationship of the mouth to the rest of the body; raising the awareness of the importance of oral health among government policy makers to create effective public policy that will improve America's oral health; and educating non-dental health professionals about oral health and disease topics and their role in assuring that patients receive good oral health care.

Silberman P, Wicker DA, Smith SH Jr., DeFries GH. **Assuring access to dental care for low-income families in North Carolina. The NC Institute of Medicine Task Force Study.** NC Med J, 61(2):95-8, March-April 2000. Comment in: NC Med J, 61(3):135, May-June 2000.

Following publication of the Task Force's recommendations for improving dental care access among low-income populations, North Carolina has taken several steps forward. The Division of Medical Assistance and the NC Dental Society are forming an advisory committee (comprising Medicaid patients, providers, and representatives from all elements of organized dentistry in the state) to review dental coverage and reimbursement rates. Using existing state funds, the NC Office of Research, Demonstrations and Rural Health Development has recruited 15 additional dentists and 1 dental hygienist to practice in community facilities serving low-income and uninsured patients. In 1999, the NC General Assembly revised the NC Dental Practice Act.

U.S. Surgeon General report reveals profound disparities in oral health of Americans. J Can Dent Assoc, 66(6):293, June 2000.

Waplington J, Morris J, Bradnock G. **The dental needs, demands and attitudes of a group of homeless people with mental health problems.** Comm Dent Health, 17(3):134-7, Sep 2000.

This study investigated the dental needs, demands and attitudes of a group of homeless people living in a hostel in Birmingham, many of whom had mental health problems. Seventy subjects underwent a dental examination. The clinical criteria for the examination were especially selected to be simple and cause minimal discomfort to the subject, but be reproducible and cover the wide range of conditions expected to be found. Five of the subjects were selected to take part in semi-structured interviews. Thirty-one per cent of the subjects were found to be edentulous, with only 32% wearing dentures. The dentate subjects had a mean DMFT (+/-SE) of 15.9 (+/-7.8). High levels of dental need were found amongst the dentate subjects who had an average of 3.6 (+/-3.9) decayed teeth and 54% had one or more teeth with obvious pulpal involvement. Eighty-five per cent of the dentate subjects had some dental wear leading to exposed dentine. The periodontal condition was generally poor, 50% of dentate subjects having excessively mobile teeth. The interviews revealed a low level of perceived need and indicated that difficulties would be encountered in tailoring

services to meet this client group's requirements. High levels of normative need were found in this group of people, however it is concluded that providing dental services to meet this need would prove difficult.

1999

McManus J, Davis M, Albert D. **Accessible dental care for children.** NY State Dent J. 65(3):24-6, March 1999.

The development of a school-based comprehensive and cost-efficient oral health care program requires careful planning centered on the needs expressed by the community. Gaining the support and the cooperation of school officials and parents creates an environment that has a significantly greater opportunity for success. Location, appropriate design of the facility and support from a local charitable organization further insure excellent access and expeditions care.

Office of Minority Health, U.S. Dept. of Health and Human Services. **Oral Health.** Closing the Gap, July 1999.

This issue of the Office of Minority Health's monthly newsletter focuses on oral health. Topics include: challenges and opportunities for oral health; dental insurance; minority dentists; school health programs; tips for new/expectant moms; dental sealants; Surgeon General's report; oral disease prevention; preventing tooth decay; smokeless tobacco use; chronic diseases; consumer information; and oral health organizations and web sites. AVAILABLE FROM: DHHS, Public Health Service, Office of Minority Health Resource Center, PO Box 37337, Washington, DC 20013-7337.

1998

Dental public health: the past, present, and future. American Association of Public Health Dentistry. American Board of Dental Public Health. J Am Dent Assoc, 117(1):171-6, July 1998.

The continued recognition process of dental public health as a specialty of dentistry served as an opportunity for the specialty to rediscover and reevaluate itself. What it found was a discipline that has evolved for 38 years to address the issues of a dynamic society. Dr. Abraham Kobren, ADA past-president has stated that public health dentistry stands as the dental conscience of the nation. The changes in dental public health mirror both changes in society and the technical changes occurring in dentistry. Identifying diseases in children is giving way to identifying diseases in adults. Access to dental care for the poor and homeless is as much a problem as is access to care for people with infectious diseases. Infection control, technology transfer, national oral health objectives, and a myriad of new financing mechanisms are some areas of change. What has remained constant is the specialty's goal to improve the oral health of the public, and its commitment to work through "organized community efforts" to achieve this goal.

1997

Eisen R. **The Shout Clinic: helping street kids build self-esteem. Shout Clinic Dental Program, Toronto, Ontario.** Ont Dent, 74(9):39-40, Nov 1997.

Waldman HB. **Homeless children.** ASDC J Dent Child, 64(6):391-394, Nov 1997.

Homeless children are an "invisible" population within our community. A review is provided of the economic, social, medical and dental conditions of these children.

1996

Clarke M, Locker D, Murray H, Payne B. **The oral health of disadvantaged adolescents in North York, Ontario.** Can J Public Health, 87:261-3, July-Aug 1996.

Disadvantaged youth, such as the homeless, the unemployed or recent immigrants, are thought to be at high risk for dental problems. Using interviews and clinical examinations, this study measured the oral health status and treatment needs of a convenience sample of 478 disadvantaged adolescents aged 14 and older in North York, Ontario. The data suggest that disadvantaged youth have high rates of oral disease. The adolescents reported a variety of symptoms, including oral pain and low rates of dental visiting. Clinically, high rates of periodontal disease, dental decay and urgent treatment needs were detected. Efforts should be made to identify high-risk groups that may be overlooked in general surveys. Prevention, detection and treatment programs should be considered for high-risk adolescents.

Crosson FB. **Mobile oral hygiene services.** Probe, 30(2):72-3, March 1996

Valla ME, Westcott RC. **Mobile dental unit brings services to the young and needy.** N Y State Dent J, 62(4):32-5, April 1996.

1995

Allukian M Jr. **Oral health: An essential service for the homeless** [editorial; comment]. J Public Health Dent, 55:8-9, Winter 1995.

Bolden AJ, Kaste LM. **Considerations in establishing a dental program for the homeless** [see comments] J Public Health Dent, 55:28-33, Winter 1995.

Use of dental services by homeless persons is low when provided in traditional settings with limited access. This study reviewed program-planning issues, focusing on the unique aspects of establishing dental programs for shelter-based persons, based on experiences of a dental program for homeless persons in Boston. The establishment of a portable dental program in 1988 involved many considerations, including determination of needs and barriers to dental care, resource identification and development, program planning and implementation, evaluation, and the development of constituency support. The diversity of the homeless population in combination with the variation of space and medical resources at different shelter sites dictates flexibility in the development of programs to address the oral health needs of the homeless.

Gaetz S, Lee J. **Developing dental services for street youth.** Ont Dent, 72(9):34-7, Nov 1995.

Kaste LM, Bolden AJ. **Dental caries in homeless adults in Boston** [see comments] J Public Health Dent, 55:34-6, Winter 1995.

OBJECTIVES: To characterize the dental caries status among users of a dental treatment and referral program at homeless shelters in Boston, MA. METHODS: Persons attending the program during a one-year period were assessed for dental caries. Decayed, missing and filled teeth (DMFT) counts were abstracted from patient records. RESULTS: The population examined (n=73) was 66% male with a mean age of 36 years. The racial composition was 51% African-American, 34% white, and 14% Hispanic. The 70 dentate people examined had a mean DFT of 11.1. The mean percent of DFT that was DT per person was 55.7%. Untreated caries were detected in 91.4% of those examined. CONCLUSIONS: There is evidence of previous dental services utilization by these individuals and a high need for preventive and restorative dental therapy.

1994

Pizem P, Massicotte P, Vincent JR, Barolet RY. **The state of oral and dental health of the homeless and vagrant population of Montreal.** J Can Dent Assoc, 60:1061-5, Dec 1994.

A study conducted in Montreal in April 1993 has made it possible to better evaluate the oral health status of homeless persons and to identify ways of making dental treatment available. Once the oral health status of this population is known, the official body responsible for homeless and vagrant individuals can be given recommendations for treatment and care. Most of the homeless are welfare recipients and have access to some benefits, including free access to basic dental services, which are available after a six-month waiting period and are provided by a dentist of the person's choice. It was hypothesized that homeless people would prefer to be treated in the shelters where they sleep, but in 65% of cases, their responses to a questionnaire indicated they preferred to visit a private dentist of their choice. Another important group (35%) wished to receive dental treatment in the hostels they frequented.

1993

Giangrego E. **Homeless find dentistry=s doors open.** CDS Review, 86(5):28-30, June 1993.

Groark CM. **Serving the underserved.** RDH, 13(4):13, April 1993.

Harmon RG. **Oral health care for the underserved in the 1990s: the HRSA perspective.** J Public Health Dent, 53(1):46-9; discussion 50-3, Winter 1993.

Purtell EP. **Indigent dental care in New Mexico.** N M Dent J, 44:14-5, Winter 1993.

1990

Warren RC. **Oral health for the poor and underserved** [see comments] J Health Care Poor Underserved, 1:169-80, Summer 1990.

1988

American Association of Public Health Dentistry and American Board of Dental Public Health. **Dental public health: the past, present, and future.** J Amer Dent Assoc, 117: 171-6, July 1988.

The continued recognition process of dental public health as a specialty of dentistry served as an opportunity for the specialty to rediscover and reevaluate itself. What it found was a discipline that has evolved for 38 years to address the issues of a dynamic society. Dr. Abraham Kobren, ADA past-president has stated that public health dentistry stands as the dental conscience of the nation. The changes in dental public health mirror both changes in society and the technical changes occurring in dentistry. Access to dental care for the poor and homeless is as much a problem as is access to care for people with infectious diseases. Infection control, technology transfer, oral health objectives, and a myriad of new financing mechanisms are some areas of change. What has remained constant is the specialty's goal to improve the oral health of the public and its commitment to work through "organized community efforts" to achieve this goal. The American Board of Dental Public Health is one of eight recognized specialties of the ADA. Topics covered are (1) history of the specialty and its impact on public health; (2) the five areas of knowledge that the specialty is built upon; (3) personnel and employment; (4) the role in the federal government; (5) state and local programs; (6) research and epidemiology; (7) geriatric dental programs; (8) infection control; (10) women in dental public health; (11) relationship to organized dentistry; and (12) trends in dental public health.

Characteristics of successful dental programs in community and migrant health centers. U.S. Dept of Health and Human Services, Bureau of Primary Health Care, July 1988.

This report examines nine representative community and migrant health centers (C/MHCs), with dental components considered to be providing high quality services at a reasonable cost, to identify and evaluate characteristics of successful C/MHC dental programs. The report also assesses the current status of prepaid programs. AVAILABLE FROM: National Clearinghouse for Primary Care Information (800) 400-BPHC

Gelberg L, Linn LS, Rosenberg DJ. **Dental health of homeless adults.** Spec Care Dent, 8:167-72, July-Aug 1988.

As part of a community-based study, we assessed the number of grossly decayed and missing teeth, as well as recent use of dental services, among 529 homeless adults. We found that 27% reported having had a toothache during the previous month (only 10% had sought help from a dentist for their toothache). Homeless adults, as compared with a general population, were half as likely to have made a dental visit within the preceding year (26.7% vs 55.0%) and had more grossly decayed teeth (means=2.3 vs means=1.4). Individuals with more tooth decay and missing teeth were more likely to be older, have physical health problems, smoke more cigarettes, use more alcohol, and have worse personal hygiene. Age, not length of homelessness, was the most important predictor variable of missing teeth. Thus, homeless adults have a higher degree of dental pathosis as well as a lower use of dental services than the general population. On the basis of these findings, more accessible dental services need to be designed for the homeless population.

Pinkham JR, Casamassimo PS, Levy SM. **Dentistry and the children of poverty.** ASDC J Dent Child, 55:17-24, Jan-Feb 1988.

This paper discussed the fact that poor people, and specifically poor children, are a problem for our society. The eradication of poverty is a goal that our nation has not been able to achieve and probably will not reach in the foreseeable future. Data that are supportive of links between poverty and increased needs for dental treatment and difficulty in the acquisition of professional dental care for children were reviewed. Social consequences surrounding the environments of poor children and, in some instances, the manner in which these children are reared, are predictive of misbehavior at dental appointments, particularly in younger age-groups. Such misbehavior, paired with the finding that these children often do need restorative and surgical care, may present challenges in patient management. Dentists must be sensitive to the problems of poor children, responsive to their psychological needs, and prepared to give the extra energy and time that may be needed in management before and during the dental appointment